

## 16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 48.

### 16.1 Enrollment

EDS enrolls FQHC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

#### Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for FQHC-related claims.

#### **NOTE:**

All nine digits are required when filing a claim.

FQHC facilities are assigned a provider type of 49 (FQHC). The valid specialty is F2 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering provider number (Block 24K) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual Medicaid provider numbers that are linked to the FQHC number. Each of these providers is assigned a provider type of 49 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to specialty table below)
- N2 (Nurse Midwife)
- N3 (Certified Registered Nurse Practitioner)
- N6 (Physician Assistant)

<b><i>Specialty (Applicable for physicians only)</i></b>	<b><i>Code</i></b>
Allergy/Immunology	03
Anesthesiology	05
Cardiac surgery and cardiovascular disease	S1
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	NI
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrics/Gynecology	16
Oncology	XI
Ophthalmology	18
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30
Rheumatology	R4
Thoracic surgery	33

<i>Specialty (Applicable for physicians only)</i>	<i>Code</i>
Urology	34
Vascular surgery	S4

### Enrollment Policy for FQHC Providers

To participate in the Alabama Medicaid Program, FQHC providers must meet the following requirements:

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites

Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

### **NOTE:**

Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants associated with the clinic must also complete enrollment applications.

FQHCs are required to notify EDS in writing within five state working days of any of the following changes:

- Losing FQHC status
- Any changes in dates in the FQHC grant budget period
- Opening(s) and/or closing(s) of any satellite center(s)
- Additions or terminations of providers

### **Patient 1<sup>st</sup> Requirements for Federally Qualified Health Centers (FQHC)**

- The clinic must be a licensed, federally recognized FQHC clinic, enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, patient management, 24 hour coverage, and other program requirements.
- The FQHC clinic (and/or site) must be opened a minimum of 40 hours per week and the physician must practice at that location a minimum of 40 hours per week to be considered a full time equivalent (FTE).
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of total patient caseload will be allowed, based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension.
- The FQHC clinic must specify what arrangements have been made for hospital admissions. If the physicians within the FQHC clinic do not have admitting privileges, then a designee must be specified. If the FQHC clinic/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1<sup>st</sup>** enrollees, including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1<sup>st</sup>** Program should be listed on the enrollment form.

### **Change of Ownership**

Medicaid must be notified within 30 calendar days of the date of a FQHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency.

## 16.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

### **NOTE:**

FQHC physicians should refer to Chapter 28, Physician, for additional information.

### **16.2.1 Benefits**

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

### **16.2.2 Limitations**

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 6, for details.

### **16.2.3 Reimbursement**

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

#### **Costs Reimbursed by Other Than FQHC Encounter Rate**

Costs reimbursed by other Medicaid programs are not reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

- Maternity care, primary contractor
- Prescription drugs by enrolled pharmacy providers

#### **NOTE:**

The dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Deleted from NOTE: See below for reporting information.

Added section: **Oral Contraceptives, Contraceptive Patch and Vaginal Ring**

#### ***Oral Contraceptives, Contraceptive Patch and Vaginal Ring***

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring will obtain these supplies from the county health department while maintaining a medical home with their chosen Plan First service provider. **Prescriptions for these supplies will not be honored at a pharmacy for Plan First patients.**

Plan First Providers are to submit an order per patient for the contraceptive method utilizing the **Plan First Patient Contraceptive Order Form**. This order will be in effect for one year from the time of the initial/annual family planning visit as dated on the order form. If changes in the contraceptive method are indicated due to patient need or preference, the patient will be required to obtain a new Plan First Patient Contraceptive Order Form from her provider.

The health department will provide oral contraceptives, the contraceptive patch and the vaginal ring as follows:

- First time users will initially receive a 3-month supply. If no problems exist upon return, the remainder of the year's supply will be issued.
- Current/Previous users will receive a 1-year supply.
- All contraceptive patch and vaginal ring users will receive a 3-month supply on a quarterly basis.

#### **NOTE:**

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

Added: Contraceptive counseling will...contraceptive pick up.

Added: For additional Plan...Manual's Appendix C.

Deleted: For accounting purposes, ...email to lpayne@medicaid.state.al.us

**NOTE:**

Costs for Maternity Care sub-contractors are not an allowable cost and are shown only in the non-reimbursable section of the cost report.

## 16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

This does not apply to dental service, however. Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter and one other encounter on the same day.

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to EDS for payment through the proper filing of claims forms. Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to EDS for payment.

## 16.3 Prior Authorization and Referral Requirements

FQHC procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1<sup>st</sup> program, refer to Chapter 39, Patient 1<sup>st</sup>, to determine whether your services require a referral from the Primary Medical Provider (PMP).

## 16.4 Cost Sharing (Copayment)

The copayment amount is \$1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

## 16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

## 16.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

FQHC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

### **NOTE:**

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

### **NOTE:**

Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own provider number on Block 24K of the CMS-1500 claim form. Enter the clinic's number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

### **16.6.1 Time Limit for Filing Claims**

Medicaid requires all claims for FQHC providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

➤ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.



## **16.6.2      *Diagnosis Codes***

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

### **NOTE:**

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

## **16.6.3      *Procedure Codes and Modifiers***

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

**NOTE:**

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

**Nurse Practitioners/Physician Assistants**

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- VFC codes, as specified in Appendix A, EPSDT
- Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List
- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Appendix O, CRNP and PA Services

**Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number.** Reimbursable services provided by an RN in an FQHC are restricted to the following:

<i><b>Procedure Codes</b></i>	<i><b>Description</b></i>
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99381-EP	Periodic EPSDT, normal, under 1 year of age
99382-EP	Periodic EPSDT, normal, 1-4 years of age
99383-EP	Periodic EPSDT, normal, 5-11 years of age
99384-EP	Periodic EPSDT, normal, 12-17 years of age
99385-EP	Periodic EPSDT, normal, 18-20 years of age
99381-EP	Periodic EPSDT, abnormal, under 1 year of age
99382-EP	Periodic EPSDT, abnormal, 1-4 years of age
99383-EP	Periodic EPSDT, abnormal, 5-11 years of age
99384-EP	Periodic EPSDT, abnormal, 12-17 years of age
99385-EP	Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years

<b>Procedure Codes</b>	<b>Description</b>
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

\* Must be approved by the Alabama Medicaid Agency to provide these services.

### **Vaccines For Children (VFC)**

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is \$8.00; it is not the rate on the pricing file.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

#### **NOTE:**

VFC codes must be billed under the FQHC's VFC number.

### **16.6.4 Place of Service Codes**

The following place of service codes apply when filing claims for FQHC services:

<b>POS</b>	<b>Description</b>
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
54	Intermediate Care/Facility/Mentally Retarded

#### **NOTE:**

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

### **16.6.5 Required Attachments**

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

#### **NOTE:**

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

## **16.7 For More Information**

This section contains a cross-reference to other relevant sections in the manual.

<b>Resource</b>	<b>Where to Find It</b>
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O